

# Inspection Report under the Long-Term Care Homes Act, 2007

Papport d'inspection Lévue le Loi de 2007 les foyers de soins de longue durée

Ministry of Health and Long-Term Care

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
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	Licensee Copy/Copie du Titulair	re Nublic Copy/Copie Public		
Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection		
May 16, 2011	2011_112_9583_16May085039	L-000555-11 Critical Incident		
Licensee/Titulaire The Corporation of the County of Elgin Municipal Homes, 465 Talbot St., East, Aylmer, ON N5H 3A5				
Long-Term Care Home/Foyer de soins de longue durée Terrace Lodge, 465 Talbot St., East, 49462 Talbot Line, Aylmer, ON N5H 3A5				
Name of Inspector/Nom de l'inspecteur Carole Alexander #112				
Inspection Summary/Sommaire d'inspection				
The purpose of this inspection was to conduct a Critical Incident inspection related abuse/neglect.				
During the course of the inspection, the inspector spoke with the Director of Care				
During the course of the inspection, the inspector reviewed the home's internal inspection, policies and procedures related to abuse and Residents' Bill of Rights. Related staff education reviewed.				
The following Inspection Protocols were used in part or in whole during this inspection: Prevention of Abuse and Neglect				
Findings of Non-Compliance were found during this inspection. The following action was taken:				
3 WN				



Ministry of Health and Long-Term ( ) re

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# NON- COMPLIANCE / (Non-respectés)

#### Definitions/Définitions

WN - Written Notifications/Avis écrit

VPC - Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité

WAO - Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes*Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. c., 8, s 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

### Findings:

On the night shift beginning March 31, 2011, residents' home environment was used by staff for the purpose of conducting the following pranks: Vaseline was placed on the cross bars and handles of 2 resident lifts. A resident door handle and linen room handle was covered with vaseline. A resident had jam applied to a brief that the resident was wearing.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. c., 8, s 3. (1) 1. Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

## Findings:

On the night shift beginning March 31, 2011, residents were subject to pranks conducted by an RN and a PSW.

A resident had jam applied to a brief he was wearing. A resident's clothing was used to develop the appearance of a resident who had fallen in her room. Jam was placed on a resident commode.

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term care home sh		HA, 2007, S.O. c., 8, s 3. (1) 5. Every licensee of a long- of residents are fully respected and promoted: 5. Every onment.	
Findings:			
On the night shift of March 31, 2011, as an April's Fools prank, staff put Vaseline on the following:			
a linen room handle, a resident's door handle, and the handles and bars of 2 resident transfer lifts.			
Inspector ID #:	112		
		Signature of Uselth System Assountability and Performance Division	
	e or Representative of Licensee e du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.	
Title:	Date:	Date of Report/May 26, 2011	